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2 **BEFORE THE ARIZONA MEDICAL BOARD**

3 In the Matter of

4 **KAREN BARCKLAY-DODSON¹, M.D.**

5 Holder of License No. **29446**
6 For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-1182A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

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8 The Arizona Medical Board ("Board") considered this matter at its public meeting on
9 October 11, 2006. Karen Barcklay-Dodson, M.D., ("Respondent") appeared with legal counsel
10 Donna McDaniel before the Board for a formal interview pursuant to the authority vested in the
11 Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact,
12 Conclusions of Law and Order after due consideration of the facts and law applicable to this
13 matter.

14 **FINDINGS OF FACT**

15 1. The Board is the duly constituted authority for the regulation and control of the
16 practice of allopathic medicine in the State of Arizona.

17 2. Respondent is the holder of License No. 29446 for the practice of allopathic
18 medicine in the State of Arizona.

19 3. The Board initiated case number MD-05-1182A after the Department of
20 Corrections reported concerns regarding Respondent's care and treatment of a forty-one year-old
21 male inmate ("BB")². On September 9, 2005 BB, who had a history of Hepatitis C, liver cirrhosis
22 and hypertension, was assaulted and sustained a one-half inch deep laceration of his upper lip

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24 ¹ Dr. Barcklay Dodson testified her current name is Barcklay, but the Board has no record of a legal name
change.

25 ² The Arizona Department of Health and BB's sister also filed complaints with the Board.

1 and multiple scalp and facial contusions. BB's main complaint was headache, nausea, upper lip
2 laceration and bloody vomiting. Respondent treated BB by repairing his upper lip laceration and
3 giving him 50 mg of Phenergan and 10 mg of Nubain to be repeated every eight hours and
4 ordering a neuro check every thirty minutes for four hours and then hourly for four hours. All
5 neuro checks were normal until 5:00 p.m. that day and BB was found dead in his cell the next
6 morning.

7 4. Respondent testified the oral information she was given when she was examining
8 BB is different from what is written in the chart and her examination and treatment of BB was
9 based on her questioning of BB and the staff who were present at the time of the incident.
10 Respondent noted one of the nurses who wrote in the chart told her the information in the chart
11 was not accurate so she went based on her interviews and not what she had been told was
12 inaccurate information in the chart. During Respondent's surgical training she had the
13 opportunity to evaluate trauma patients and treat patients with head injuries and the standard of
14 care in her training was if a patient had lost consciousness, or had shown any signs of
15 disorientation, or any abnormal neurological examination, she needed to get a head CT and any
16 other evaluation indicated by the results of the CT. The Board confirmed that mechanism of the
17 injury and a thorough neurological examination is also important for her consideration.
18 Respondent noted that working in the prison system there are extenuating factors that make
19 things more difficult, such as security issues that prevent her from having a one-on-one
20 conversation with the patient after a fight, and that inmates do not want to be known as a "rat" or
21 "snitch" and they clam up and do not give information. Respondent noted she had to find
22 alternate routes of getting information, such as from nursing staff who responded, or security staff
23 who were first on the scene. Respondent also noted there were transportation issues and the
24 treatment area is not set up as an emergency room.

1 5. The Board directed Respondent to page five of the medical record and noted a
2 registered nurse wrote this note and asked Respondent to read the first few lines. Respondent
3 read "inmate found lying on floor on his back. Face and head is bloody. Emesis on his clothing,
4 undigested food. Just returning from breakfast. Per security, inmate was punched, then once he
5 fell to the floor, was repeatedly kicked in his head. Security states inmate did lose
6 consciousness." The Board asked if Respondent was handed this note when she first went to
7 see BB. Respondent testified she was not and, although her notes follow this note, when she first
8 went to see BB she did not read the chart, but interviewed and examined BB and got more
9 information from the nurse and security. Respondent first saw the nurse's note after she had
10 completed her examination and was documenting it in the chart.

11 6. The Board confirmed Respondent's note under "Subjective" was "[i]nmate does
12 not remember assault. Disoriented to person, place, time. Complains of severe headache and
13 vomiting." The Board asked if, based on her surgical training, it would raise a red flag that a
14 person who was kicked about the head by multiple people was complaining of severe headache
15 and vomiting in terms of his having more than just a minor injury. Respondent noted she would
16 agree if BB had been projectile vomiting, but his vomiting was explained by the bleeding from his
17 nose and his having swallowed blood, especially since the vomiting stopped when the nosebleed
18 stopped. Respondent's physical examination included an examination of the nose, the bleeding,
19 palpation and looking for deformities, asking about tenderness and checking the lip laceration.
20 Respondent documented that the vomitus was clotted blood likely due to the nasal bleeding.

21 7. The Board noted BB ultimately died from an intracranial bleed and skull fracture
22 and asked whether it had been Respondent's experience in examining head trauma patients that
23 she can feel swelling of the scalp and some fluctuance of the scalp or facial areas when you have
24 a skull fracture. Respondent said it had not always been her experience and BB did not have
25 swelling, tenderness, or induration. Respondent noted she had seen patients with small non-

1 displaced fractures who did not have any of these symptoms, but they develop it later after the
2 examination. The Board directed Respondent to page six of the autopsy, specifically the gross
3 examination of the head and neck and asked her to read this description. Respondent read
4 "[o]ver the superior parietal and frontal scalp are multiple irregular to ovoid right brow abrasions
5 and purple contusions covering a 14-by-12 centimeter area. Contusion of the left frontal parietal
6 scalp has a similar geometric pattern and is over a 5-by-4-centimeter area. A purple 2-by-1.2-
7 centimeter contusion is over the medial left upper eyelid." Respondent agreed this description did
8 not sound like the patient she saw with the relatively benign examination she documented in the
9 prison's medical facility, but noted the contusions had not developed at the time of her
10 examination or she would have sent him immediately to the emergency room.

11 8. Respondent could not remember how long after the assault she saw BB, but
12 agreed there was a time gap between the assault and when she saw BB and that over a period of
13 time bruises and contusions become more obvious and uglier. Respondent indicated she was
14 aware BB had a history of hepatitis C and cirrhosis and that this placed him at increased risk for
15 an intracranial hemorrhage after a blunt injury. The Board noted the autopsy revealed a thirteen
16 centimeter linear skull fracture over BB's right temporal parietal scalp, but Respondent testified
17 earlier she might not feel a small non-displaced fracture. The Board suggested thirteen
18 centimeters was not a small fracture and asked whether Respondent thought she appropriately
19 palpated BB's face and scalp when she examined him. Respondent testified she believed she
20 was thorough and, in her past experience, tenderness from a fracture is not hard to elicit and
21 does not require excessively deep palpation. Respondent testified she sewed up the laceration
22 on BB's lip and ordered he go to the observation cell that has a camera allowing him to be
23 observed twenty-four hours per day and, per security guidelines, he would be checked after thirty
24 minutes. Respondent noted BB was never taken to that cell. The Board directed Respondent to
25 the evidence showing she ordered vital sign and neuro checks for eight hours. Respondent

1 agreed and indicated she ordered this knowing it took time to move inmates from one area to
2 another and the checks were to cover the time until he got to the observation cell where he would
3 then be monitored every thirty minutes until he was cleared by medical personnel.

4 9. The Board asked Respondent's experience in getting prompt CTs when she sent
5 patients to the emergency room in Yuma. Respondent noted if the inmates are sent by
6 ambulance and are unconscious when they are picked up, the CT happens very quickly, but if
7 they are walking, talking, making perfect sense and perfectly oriented, it would take up to twelve
8 or more hours, depending on how busy the emergency room is. The Board also noted there is no
9 neurosurgery in Yuma. The Board confirmed that in certain types of head injuries there is a lucid
10 interval where the patient appears normal prior to becoming obtunded and showing neurological
11 signs of an intracranial bleed. Respondent agreed and noted this is why she ordered
12 observation. The Board asked if it made more sense in this day and age, especially if you are a
13 long way from definitive neurosurgical care, that you do the scan to prove there is no bleed and
14 then observe rather than proceeding the other way around. Respondent testified that she was
15 taught in her training when she ran into delays of twelve hours or more that she can rule things
16 out by time, and, because of the number of head injuries in the prison, not all of them go out.
17 Respondent noted in BB's case he truly gave her no indication the injury was that severe and she
18 checked and double-checked and triple-checked with the security staff and the nursing staff to
19 verify what they said was the report of loss of consciousness was not correct and the report of his
20 being stomped on the head was not correct, and it had been a simple assault – meaning they got
21 in a punch or two before it was broken up.

22 10. The Board noted the nurse's chart entries suggest BB was pummeled rather
23 severely by several people. Respondent testified this is why she asked again and again what
24 happened to make sure she was getting the correct information. Respondent testified she
25 performed a basic range of motion and palpation of BB's neck and noted he was moving his neck

1 on his own and she did not ask him to further move his neck and observed what he was doing.
2 Respondent did not document anything about a neck examination. The Board asked if
3 Respondent performed a neurologic examination in terms of motor, cerebellar, sensory function.
4 Respondent testified she observed BB's gait, balance and his movements, but BB was not
5 entirely cooperative, did not want to be in medical anymore, and just wanted his lip sewn up so he
6 could go back to his cell. Respondent testified BB was angry. The Board noted its Medical
7 Consultant criticized Respondent for giving sedating medications to a patient who suffered a head
8 injury and asked why she gave BB Phenergan. Respondent gave the Phenergan because of
9 BB's history of hepatitis C and cirrhosis and the fact that he had an increased potential to bleed
10 and could not take Tylenol. Respondent weighed the options of what to do on giving him pain
11 medications that frequently cause nausea and it was to avoid nausea. The Board noted BB was
12 already nauseous. Respondent did not want to make it worse, and agreed a head injury can
13 cause nausea.

14 11. Respondent still works at the prison and feels she is relatively skilled in evaluating
15 patients with head injuries. Based on this case, Respondent is now much less trusting of the
16 reports she gets from security and nursing and is more prone to send the patient to the
17 emergency room to get the scan whether the inmate appears to have a neurologic deficit or even
18 if it is an inmate report of loss of consciousness. The Board confirmed if Respondent sent too
19 many prisoners for head scans and received negative results she would be questioned by her
20 employer.

21 12. The Board asked what kind of physical examination Respondent performed that
22 would have led her to miss a large contusion. Respondent testified she was really surprised that
23 BB was non-tender on palpation and she did not feel any step-offs, there was no foginess from
24 swelling, and the contusions had not yet shown themselves and she wondered retrospectively if
25 BB was just anxious to get to his cell because he was answering "no" to all her questions. The

1 Board asked the possible reasons for a nosebleed in a blunt head trauma. Respondent testified
2 BB could have had a fracture but, there was no ring from CSF fluid from when blood hit the paper
3 – if there had been he would have been sent to the emergency room. Respondent testified BB
4 could also have had a nasal fracture and she sees quite a number of nasal fractures.

5 13. The Board directed Respondent back to her note and the nurse's note from the
6 day of the incident and noted the nurse's note reflects a significant and major head trauma. The
7 nurse's note is timed at 9:30 and Respondent's note is dated 10:50. The Board asked at what
8 point in time she became aware of the nurse's note. Respondent saw the nurse's note when she
9 went to write her own note and that is when she went back to ask if the note was what really
10 happened because, if it was, it would have changed her plan completely. Respondent testified
11 the nurse told her his note was just an initial report that turned out to be from inmates and
12 security who witnessed the incident said it did not happen that way and they had not found BB
13 unconscious. Accordingly, Respondent based everything on her own investigation rather than
14 relying solely on the nurse's note and that is why she went and talked to BB and tried to get
15 information from him.

16 14. The Board asked if Respondent considered that vomiting is a cardinal sign
17 indicative of head injury because of increased intracranial pressure that is developing and there
18 may be something going on inside that a physician is not aware of by external examination.
19 Respondent testified she was taught that vomiting due to increased intracranial pressure would
20 be projectile vomiting and had the vomiting not stopped when the nosebleed stopped it would not
21 have mattered whether it was projectile or not, she would have wanted further evaluation.

22 15. The Board asked what Respondent took from her note that BB "[did] not remember
23 assault." Respondent testified it was common to get that from inmates because they do not want
24 to talk about what happened in front of security and in these situations she looks at whether they
25 appear agitated and every time she asked BB a question about what happened he gave a furtive

1 glance to the officer. "I don't know" was the only thing BB would answer and if she asked anything
2 else, such as orientation to person, place and time, he was able to answer without any difficulties.
3 The Board confirmed BB's saying he did not remember the assault could also have indicated
4 amnesia or that he had a loss of consciousness. The Board asked, in light of BB not
5 remembering the assault and his complaints of severe headache and vomiting, which version of
6 events seemed more plausible, the nurse's written version or the version she developed from her
7 questioning. Respondent testified that just looking at the note and knowing that he did not
8 remember the assault she would be inclined to think the nurse's note was accurate. The Board
9 asked which would Respondent act upon, giving BB the benefit of the doubt. Respondent
10 testified if she just retrospectively went and looked through the chart, probably the nurse's note.
11 The Board asked the standard of care for treating BB or any other patient with severe head
12 trauma. Respondent testified that retrospectively she would have sent BB to the emergency
13 room to get a head CT, even if he had to wait twelve hours.

14 16. The Board asked if Respondent felt she met the standard of care in treating BB.
15 Respondent testified that retrospectively looking at the case and knowing the outcome in the
16 autopsy report, she would say no, but based on the information she had at the time, she would
17 say yes.

18 17. The Board noted the environment Respondent worked in was a mitigating factor
19 and that it is not clear the outcome would have been different had Respondent recognized the
20 head trauma.

21 18. The standard of care requires the physician to complete a thorough history, and
22 physical and make appropriate medical decisions in the context of a blunt head injury.

23 19. Respondent deviated from the standard of care because she did not complete a
24 thorough history and physical and make appropriate medical decisions in the context of a blunt
25 head injury.

20. Respondent did not recognize and treat BB's head trauma.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

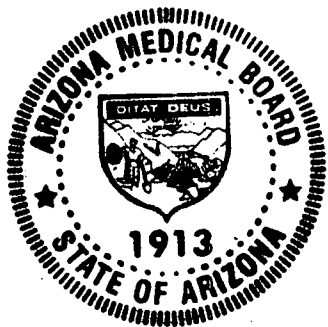
Respondent is issued a Letter of Reprimand for failure to appropriately evaluate and refer a patient with a significant head injury.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

1 DATED this 7th day of December, 2006.



THE ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

7 ORIGINAL of the foregoing filed this
8 8th day of December, 2006 with:
9 Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

10 Executed copy of the foregoing
11 mailed by U.S. Mail this
8th day of December, 2006, to:

12 Donna McDaniel
13 Bihn & McDaniel, PLC
3101 North Central Avenue – Suite 200
Phoenix, Arizona 85012-0001

14 Karen Barcklay-Dodson, M.D.
15 Address of Record

16 *Dr. M. Gra*
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